MEMORANDUM

TO: **Health Services and Development Agency**

FROM: **Jim Christoffersen, General Counsel**

RE: **Emergency Rulemaking**

DATE: **May 20, 2016**

Public Chapter 1043, a copy of which is attached, makes significant changes to the certificate of need statute and budget. Copies of the fiscal note submitted by Agency staff and that of the Legislature's Fiscal Review staff are also attached.

Pursuant to Pub. Ch. 1043, effective 7/1/16, the Agency will be required to adjust fees as necessary to become fiscally self-sufficient. *See* Section 20. That means covering the approximately $150,000 - $200,000 in monies for the Agency's budget that are not presently covered by application fees. Pub. Ch. 1043 compounds this task by eliminating a number of activities that currently require a CON, which is expected to result in foregone revenue of more than $400,000, due to lost application fees. The bulk of the lost revenue is expected to result from eliminating the capital thresholds and major medical equipment requirements. Further compounding the fiscal challenge is the numbers: there will be fewer applications, and approximately ½ of those remaining are presently minimum fee applications ($3,000 each). In other words, 18 minimum fee applications must, along with 18 other remaining applications, make up for the loss of most maximum $45,000 applications.

Representatives from the Department of Finance and Administration have confirmed that the Agency must look at cost-cutting measures and raise fees to cover this gap – roughly ½ of the Agency's budget. Since the Agency already has one of the smallest staffs in state government, which will go from 10 employees to 8 to cut costs, most of the hole must be plugged through "adjusting" fees – upward. That's what the law says to do.

Attached are proposed changes to the Agency's fees, including:

- increased filing fees, minimum and maximum filing fees; and
- several cost-recoupment measures.

The Agency will consider whether to adopt these changes or modified changes at its May 25, 2016 meeting,

State of Tennessee

PUBLIC CHAPTER NO. 1043

SENATE BILL NO. 1842

By Gardenhire, Watson

Substituted for: House Bill No. 1730

By Cameron Sexton, Daniel, Matheny, Clemmons

AN ACT to amend Tennessee Code Annotated, Title 68, relative to certificate of need.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 68-11-1602, is amended by deleting subdivision (12) in its entirety.

SECTION 2. Tennessee Code Annotated, Section 68-11-1602, is further amended by adding the following as a new subdivision to be appropriately designated:

( ) "Pediatric patient" means a patient who is fourteen (14) years of age or younger;

SECTION 3. Tennessee Code Annotated, Section 68-11-1602(7)(A), is amended by deleting the subdivision in its entirety and substituting instead the following:

(A) "Healthcare institution" means any agency, institution, facility, or place, whether publicly or privately owned or operated, that provides health services and that is one (1) of the following: nursing home; recuperation center; hospital; ambulatory surgical treatment center; mental health hospital; intellectual disability institutional habilitation facility; home care organization or any category of service provided by a home care organization for which authorization is required under part 2 of this chapter; outpatient diagnostic center; rehabilitation facility; residential hospice; or nonresidential substitution-based treatment center for opiate addiction;

SECTION 4. Tennessee Code Annotated, Section 68-11-1605(5), is amended by inserting the language "the quality of health care to be provided and" between the language "and consider" and "the health care needs".

SECTION 5. Tennessee Code Annotated, Section 68-11-1607(a), is amended by deleting subdivision (a)(2) in its entirety.

SECTION 6. Tennessee Code Annotated, Section 68-11-1607(a)(4), is amended by deleting the subdivision and substituting instead the following:

(4) Initiation of any of the following healthcare services: burn unit, neonatal intensive care unit, open heart surgery, organ transplantation, cardiac catheterization, linear accelerator, positron emission tomography, home health, hospice, psychiatric, or opiate addiction treatment provided through a nonresidential substitution-based treatment center for opiate addiction;

SECTION 7. Tennessee Code Annotated, Section 68-11-1607(a), is further amended by deleting subdivision (a)(6) in its entirety.

SECTION 8. Tennessee Code Annotated, Section 68-11-1607(a), is further amended by deleting subdivision (a)(7) in its entirety.

SECTION 9. Tennessee Code Annotated, Section 68-11-1607(a), is further amended by deleting subdivision (a)(9) in its entirety.

SECTION 10. Tennessee Code Annotated, Section 68-11-1607(a), is further amended by adding the following as new subdivisions (a)(10) and (a)(11):

(10) Initiation of magnetic resonance imaging:

(A) In any county with a population in excess of two hundred fifty thousand (250,000) according to the 2010 federal census or any subsequent federal census, only for providing magnetic resonance imaging to pediatric patients; and

(B) In any county with a population of two hundred fifty thousand (250,000) or less according to the 2010 federal census or any subsequent federal census, for providing magnetic resonance imaging to any patients;

(11) Increasing the number of magnetic resonance imaging machines, in any county with a population of two hundred fifty thousand (250,000) or less according to the 2010 federal census or any subsequent federal census, by one (1) or more, except for replacing or decommissioning an existing machine;

(12) Establishing a satellite emergency department facility by a hospital at a location other than the hospital's main campus;

SECTION 11. Tennessee Code Annotated, Section 68-11-1607(g), is amended by deleting the subsection in its entirety and by substituting instead the following:

(g)(1)(A)(i) Notwithstanding subdivision (a)(3)(A) or (a)(5), no more frequently than one (1) time every three (3) years, a hospital, rehabilitation facility, or mental health hospital may increase its total number of licensed beds in any bed category by ten percent (10%) or less of its licensed capacity at any one (1) campus over any period of one (1) year for any services or purposes it is licensed to perform without obtaining a certificate of need. The hospital, rehabilitation facility, or mental health hospital shall provide written notice of the increase in beds to the agency on forms provided by the agency prior to the request for licensing by the board for licensing healthcare facilities or the department of mental health and substance abuse services, whichever is appropriate.

(ii) A hospital, rehabilitation facility, or mental health hospital shall not:

(*a*) Increase its number of licensed beds for any service or purpose for which it is not licensed to provide; or

(*b*) Redistribute beds within its bed complement to a different category.

(B) For the purposes of this subsection (g), "campus" means structures and physical areas that have the same address and are immediately adjacent or strictly contiguous to the facility's or hospital's main buildings.

(2) For new hospitals, rehabilitation facilities, or mental health hospitals, the ten percent (10%) increase authorized by subdivision (g)(1) cannot be requested until one (1) year after the date all of the new beds were initially licensed.

(3) When determining projected county hospital bed need for certificate of need applications, all notices filed with the agency pursuant to subdivision (g)(1), with written confirmation from the board for licensing healthcare facilities or the department of mental health and substance abuse services, whichever is appropriate, that a request and application for license has been received and a review has been scheduled, shall be considered with the total of licensed hospital beds, plus the number of beds from approved certificates of need, but yet unlicensed.

SECTION 12. Tennessee Code Annotated, Section 68-11-1607(i), is amended by deleting from the first sentence the language "lithotripters".

SECTION 13. Tennessee Code Annotated, Section 68-11-1607, is amended by adding the following as new subsections:

(n)(1) Any person who provides magnetic resonance imaging services shall file an annual report by March 1 of each year with the agency concerning adult and pediatric patients that details the mix of payors by percentage of cases for the prior calendar

year for its patients, including private pay, private insurance, uncompensated care, charity care, medicare, and medicaid.

(2) In any country with a population in excess of two hundred fifty thousand (250,000) according to the 2010 federal census or any subsequent federal census, any person who initiates magnetic resonance imaging services shall notify the agency in writing that imaging services are being initiated and shall indicate whether pediatric patients will be provided imaging services.

(o)(1) An application for certificate of need for organ transplantation shall separately:

(A) Identify each organ to be transplanted under the application; and

(B) State, by organ, whether the organ transplantation recipients will be adult patients or pediatric patients.

(2) After an initial application for transplantation has been granted, the addition of a new organ to be transplanted or the addition of a new recipient category shall require a separate certificate of need; the application shall:

(A) Identify the organ to be transplanted under the application; and

(B) State whether the organ transplantation recipients will be adult patients or pediatric patients.

(3)(A) For the purposes of certificate of need approval for organ transplantation programs under this part, any program submitted to the United Network for Organ Sharing (UNOS) by January 1, 2017, shall not be required to obtain a certificate of need.

(B) If the organ transplantation program ceases to be a UNOS-approved program, then a certificate of need shall be required.

(p) After receiving a certificate of need, an outpatient diagnostic center shall become accredited by the American College of Radiology in the modalities provided by that facility within a period of time set by rule by the agency as a condition of receiving a certificate of need.

SECTION 14. Tennessee Code Annotated, Section 68-11-1608(a)(5), is amended by inserting the language "any applicable quality measures under § 68-11-1609(b) and" between the language "consistent with" and "the state health plan".

SECTION 15. Tennessee Code Annotated, Section 68-11-1609(b), is amended by inserting the language "will provide health care that meets appropriate quality standards," between the language "and maintained," and "and will contribute".

SECTION 16. Tennessee Code Annotated, Section 68-11-1609, is amended by adding the following as a new subsection:

( ) The agency shall maintain continuing oversight over any certificate of need that it approves on or after July 1, 2016. Oversight by the agency shall include requiring annual reports concerning continued need and appropriate quality measures as determined by the agency. The agency may impose conditions on a certificate of need that require the demonstration of compliance with continued need and quality measures; provided, that conditions for quality measures may not be more stringent than those measures identified by the applicant in the applicant's submitted application.

SECTION 17. Tennessee Code Annotated, Section 68-11-1609, is further amended by adding the following as a new subsection:

( ) If an applicant's application is denied by the agency, then the applicant shall receive on request a refund equal to twenty-five percent (25%) of the examination fee for its application.

SECTION 18. Tennessee Code Annotated, Section 68-11-1610, is amended by adding the following as a new subsection:

( ) If a person, who is not the applicant or the agency, seeks review of a decision in a contested case, then that person shall file an appeal fee equal to twenty-five percent (25%) of the examination fee for the application that was filed in the case.

SECTION 19. Tennessee Code Annotated, Section 68-11-1617(e), is amended by adding the following as a new subdivision to be appropriately designated:

( ) The failure to meet a quality standard applicable to the violator.

SECTION 20. Tennessee Code Annotated, Section 68-11-1623, is amended by deleting the section in its entirety and substituting instead the following:

(a) All fees and civil penalties authorized by this part, with the exception of fees established pursuant to § 68-11-1625, shall be paid by the health services and development agency or the collecting agency to the state treasurer and deposited in the state general fund and credited to a separate account for the agency. Fees include, but are not limited to, fees for the application of certificates of need, subscriptions, project cost overruns, copying, and contested cases. Disbursements from that account shall be made solely for the purpose of defraying expenses incurred in the implementation and enforcement of this part by the agency. Funds remaining in the account at the end of any fiscal year shall not revert to the general fund but shall remain available for expenditure in accordance with law.

(b) The agency shall prescribe fees by rule as authorized by this part. The fees shall be in an amount that provides for the cost of administering the implementation and enforcement of this part by the agency. Fees prescribed by the agency shall be adjusted as necessary to provide that the account is fiscally self-sufficient and that revenues from fees do not exceed necessary and required expenditures.

SECTION 21. Tennessee Code Annotated, Title 68, Chapter 11, Part 16, is amended by adding the following as a new section to be appropriately designated:

(a) In consultation with the state health planning division and the board for licensing healthcare facilities or the department of mental health and substance abuse services, whichever is appropriate, and subject to Section 16 of this act, the agency shall develop measures by rule for assessing quality for entities that, on or after July 1, 2016, receive a certificate of need under this part. In developing quality measures, the agency may seek the advice of stakeholders with respect to certificates of need for specific institutions or services.

(b) If the agency determines that an entity has failed to meet the quality measures developed under this section, the agency shall refer that finding to the board for licensing healthcare facilities or the department of mental health and substance abuse services, whichever is appropriate, for appropriate action on the license of the entity under part 2 of this chapter.

(c) If the agency determines that an entity has failed to meet any quality measure imposed as a condition for a certificate of need by the agency, the agency may impose penalties pursuant to § 68-11-1617 or revoke a certificate of need pursuant to § 68-11-1619.

SECTION 22. If any provision of this act or its application to any person or circumstance is held invalid, then the invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end the provisions of this act shall be severable.

SECTION 23. This act shall take effect July 1, 2016, the public welfare requiring it. This act shall apply to applications filed on or after July 1, 2016.

SENATE BILL NO. 1842

PASSED: April 20, 2016

RON RAMSEY
SPEAKER OF THE SENATE

BETH HARWELL, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 28th **day of** April **2016**

BILL HASLAM, *GOVERNOR*

FISCAL REVIEW COMMITTEE
OFFICIAL SUPPORT FORM
Revised December 2010

1. General Information

***Bill or Amendment Number(s): HB 1730, Amendment #015533**

Original Bill
Corrected Bill
X Amendment(s)
Corrected Amendment(s)

*Department: Health Services and Development Agency

*Date: April 8, 2016

*Preparer: Jim Christoffersen, General Counsel

*Phone: 741-2364

*Preparer's E-mail (hit return to make hyperlink): jim.christoffersen@tn.gov

==========

2. *Explain specifically how this bill or amendment will impact your department or programs.

This bill would have a significant impact upon the Health Services and Development Agency and/or the General Fund in its current form. Also, it has a broad caption.

==========

3. State Fiscal Impacts (Boxes will expand as information is typed.)

Increase State Expenditures

Fiscal Year	One-Time	Recurring	Fund Affected
	None	$7,000 - $20,000	General Fund

The bill would require the Health Services and Development Agency to refund 25% of the "examination [sic] fee" to applicants whose application is denied. Filing fees for denied projects have ranged recently from approximately $27,000 to greater than 80,000 in a given year, 25% of which would be approximately $7,000 - $20,000. Therefore, it is anticipated that state expenditures would be increased by approximately $7,000 - $20,000 each FY going forward.

Decrease State Expenditures

Fiscal Year	One-Time	Recurring	Fund Affected
	None	Not significant	General Fund

Increase State Revenue

Fiscal Year	One-Time	Recurring	Fund Affected
	None	$16,500	General Fund

If a CON requirement were added for the initiation of organ transplantation services, there might be a slight increase in CON applications. Health Services and Development Agency staff lacks information to project how many applications might result, but very few are anticipated. This would not have a significant fiscal impact.

If a CON requirement were added for increasing the number of magnetic resonance imaging machines in any county with a population of 250,000 or less according to the 2010 federal census or any subsequent federal census, by one (1) or more, except for replacing or decommissioning an existing machine, there would be an increase in CON applications. Current law permits existing providers to add machines, at a cost of less than $2 million, without another CON; in this state, approximately 2 machines are added without a CON this way per FY, sometimes fewer. Therefore, it is expected that between 1-2 CON applications would be filed each FY under the proposed requirement, resulting in an addition of 5,5,000 to the General Fund each FY.

The bill would require a person who is initiating a contested case appealing an agency decision to approve a CON application to "file an appeal fee equal to" 25% of the examination [sic] fee for the "application that was filed in the case." Based upon the filing fees of applications received during FY 12/13, 13/14 and 14/15, it is anticipated that state revenue would be increased by approximately $10,000 each FY under this provision.

The bill spells-out the existing CON requirement for establishing an off-campus hospital emergency room. This is already required, and applications (and, therefore, fees) have been received for several fiscal years already. Therefore, revenue would not change as a result.

*The bill directs the Health Services and Development Agency to adjust fees by rule to provide that the program is self-sufficient. The only way to make this bill revenue neutral and accomplish that would be a significant escalation of fees for the remaining 30+ anticipated CON applications to raise approximately $600,000 (becoming self-sufficient would mean no longer receiving the approximately $150,000 - $200,000 from the General Fund per FY, on top of replacing the revenue foregone by this bill) - an average of nearly $20,000 per application in addition to the current fees. The only way this can occur is via Emergency Rulemaking and anticipated resistance by some regulated entities, and possibly, during legislative oversight.

Decrease State Revenue

Fiscal Year	One-Time	Recurring	Fund Affected
	$25,000	$410,000	General Fund

If state revenue is forgone, denote amount, fiscal year(s) and explain why the department believes it is forgone as opposed to a decrease:

<u>One Time</u>

While continuing to assess the unintended consequences of the many changes in this bill, HSDA staff realized that two huge contested case appeals will go away because the CON requirements subject to the disputed applications will be eliminated, namely "major medical equipment in excess of $2 million" (East Tennessee Radiation Therapy Services application) and modifications of a hospital in excess of $5 million and increasing beds (Centennial Medical Center application). The Administrative Procedures Division of the Secretary of State's Office bills the HSDA an hourly rate for the time of Administrative Judge's. Many ALJ hours have been spent on these cases. TCA 68-11-1610 provides that the loser shall pay these fees, which comes in the form of reimbursement to the HSDA. If these cases simply go away before appeals have been exhausted, there will be no "losing party." Therefore, the HSDA will not receive the anticipated $27,000 in reimbursed ALJ fees.

Recurring

Certificate of Need [CON] Application fees go to the General Fund. The elimination of any activity requiring a CON could reduce state revenue. This bill, as amended, would eliminate activities requiring a CON, as follows.

If the CON requirement for modification of a health care institution, other than a hospital, including renovations and additions to facilities, where such modification requires a capital expenditure greater than $2 million, there would be fewer applications for a certificate of need. It is expected that a reduction of $40,000 to the General Fund would result in each fiscal year going forward.

If the CON requirement for modification of a hospital, including renovations and additions to facilities, where such modification requires a capital expenditure greater than $5 million, there would be fewer applications for a certificate of need. Application fees for such projects averaged approximately $300,000 during FY 12/13, 13/14, and 14/15. It is expected that a reduction of $290,000 to the General Fund would result in each fiscal year going forward.

If a provision were added to the statute permitting a hospital, rehabilitation facility, or psychiatric hospital to increase its total number of licensed beds in any bed category by 10% or less of its licensed bed capacity at any 1 campus over any 3 year period for any services or purposes it is licensed to perform without obtaining a CON, it is likely that there would be very few CON applications for the increase in the total number of beds in any bed category at any hospital, rehabilitation facility, or psychiatric hospital. It is rare for any such facility to seek to expand by greater than 10% in any 3 year period, and most wishing to increase their licensed bed capacity in any category by 10% - 20% could simply avoid CON altogether by increasing by 10% one year and waiting three years to add 10% more. This would be particularly easy if combined with the elimination of the $5 million threshold, as the amended bill would do; e.g., a hospital could construct a large addition of millions to greater than $100 million that would be filled over a period of several years as the new beds come on line, with the ability to repeat every three years. When analyzing CON applications since 2012, only several were for appreciably more beds than this amendment would allow, and thus, changing the amendment from once every year to once every three years has no material impact upon the initial analysis. Application fees for such projects that did not exceed $5 million in project cost averaged approximately $30,000 during FY 12/13, 13/14, and 14/15. **An additional $30,000 in average FY filing fees would be lost, looking at the elimination of this requirement in a vacuum, but have already been counted in the elimination of the $5 million threshold, elsewhere in the bill, as there were applications filed for both reasons.*

If the $2 million threshold for acquisition of major medical equipment were eliminated, the reduction in certificate of need application fees received into the General Fund would average approximately $20,000 in each FY going forward, based upon the average from FY 12/13, 13/14, and 14/15. *This estimate could easily double, if looking at the elimination of this requirement in a vacuum, but have already been counted in the elimination of the $5 million threshold, elsewhere in the bill, as there were applications filed for both reasons. *This estimate could easily double, if looking at the elimination of this requirement in a vacuum, but have already been counted in the elimination of the $5 million threshold, elsewhere in the bill, as there were applications filed for both reasons.

If the CON requirement for initiation of swing bed services is eliminated, there would be fewer applications for a certificate of need. One application has been received in the past three Fiscal Years. On average, it is expected that a reduction of $1,000 to the General Fund would result in each fiscal year going forward.

If the CON requirement for initiation of magnetic resonance imaging services is eliminated in counties with a population of 200,000 or greater, there would be fewer applications for a certificate of need. These counties include Shelby, Davidson, Knox, Hamilton and Rutherford. The reduced applications for this change averaged approximately $25,000 during FY 12/13, 13/14, and 14/15. Magnetic resonance imaging services limited to pediatric patients are very rare, and therefore, it is not expected that there will be many, if any, applications to establish same. It is expected that a reduction of $25,000 to the General Fund would result in each fiscal year going forward.

If the CON requirement for initiation of extracorporeal lithotripsy services is eliminated, there would be fewer applications for a certificate of need. The reduced applications for this change averaged $2,000 during FY 12/13, 13/14, and 14/15. It is expected that a reduction of $2,000 to the General Fund would result in each fiscal year going forward.

If the CON requirement for discontinuation of any obstetrical or maternity service is eliminated, there would be fewer applications for a certificate of need. The reduced applications for this change averaged $2,000 during FY 12/13, 13/14, and 14/15. It is expected that a reduction of $2,000 to the General Fund would result in each fiscal year going forward.

If the CON requirement is eliminated for the closing of any hospital that has been designated as a critical access hospital under the Medicare rural flexibility program or the elimination in the hospital of any services for which a certificate of need is required, the fiscal impact would not be significant. There has never been an application for this type of action. It is unlikely that this would have a significant impact.

If the CON requirement for the establishment of a birthing center were eliminated, there would be fewer applications for a certificate of need; however, there are few such applications, historically. It is unlikely that this would have a significant impact.

If the dollar amount or source of funding will change beyond the first two fiscal years, please state the change:

There is no reason to expect the dollar amount or source of funding to change beyond the first two fiscal years.

4. Local Fiscal Impacts

Increase Local Expenditures

Fiscal Year	One-Time		Recurring	
	Mandatory	Permissive	Mandatory	Permissive
	None	None	None	None

Decrease Local Expenditures

Fiscal Year	One-Time		Recurring	
	Mandatory	Permissive	Mandatory	Permissive
	None	None	None	None

Increase Local Revenue

Fiscal Year	One-Time		Recurring	
	Mandatory	Permissive	Mandatory	Permissive
	None	None	None	None

Decrease Local Revenue

Fiscal Year	One-Time		Recurring	
	Mandatory	Permissive	Mandatory	Permissive
	None	None	None	None

Additional Explanation of local impact if desired:

If local revenue is forgone, denote amount, fiscal year(s) and explain why the department believes it is forgone as opposed to a decrease:

5. Federal Fiscal Impacts

Increase Federal Expenditures

Fiscal Year	One-Time	Recurring	Fund Affected
	None	None	None

Identify which federal programs these funds are attached to:

If the dollar amount or source of funding will change beyond the first two fiscal years, please state the change:

Decrease Federal Expenditures

Fiscal Year	One-Time	Recurring	Fund Affected
	None	None	None

Identify which federal programs these funds are attached to:

If the dollar amount or source of funding will change beyond the first two fiscal years, please state the change:

Increase Federal Revenue

Fiscal Year	One-Time	Recurring	Fund Affected
	None	None	None

Identify which federal programs these funds are attached to:

If the dollar amount or source of funding will change beyond the first two fiscal years, please state the change:

Decrease Federal Revenue

Fiscal Year	One-Time	Recurring	Fund Affected
	None	None	None

Identify which federal programs these funds are attached to:

If the dollar amount or source of funding will change beyond the first two fiscal years, please state the change:

==========

6. Other Fiscal Impacts (If the impact cannot be placed into the above fields, is not specifically quantifiable, is a cost avoidance, or if additional information is needed to explain the fiscal impact(s) use the space below):

None for the Health Services and Development Agency

==========

7. *Assumptions Used to Determine Fiscal Impact/Breakdown of Impact: (Indicate number and type of positions; show personnel costs, benefits, supplies, equipment, travel, etc. Attach copies of worksheets, if needed. Include assumptions for zero impacts).

This bill would have a significant impact upon the Health Services and Development Agency and/or the General Fund in its current form. Also, as introduced, the bill has a broad caption.

As detailed above, the combined reduction in revenue to the General Fund would be $410,000 each FY going forward. The Health Services and Development Agency pays application fees into the General Fund, and its budget is funded from the General Fund.

The Health Services and Development Agency has a bare-bones staff of 9 employees. The reduction in applications contemplated might have enabled the elimination of two positions, totaling $130,691 with benefits. There are no other positions that could be eliminated without losing services that would still be necessary to handle the remaining duties of the certificate of need program, which already operates lean. However, the bill directs the Health Services and Development Agency to perform additional duties that generates no revenue, namely developing quality standards and review of reporting with respect to certain issued certificates of need and follow-up actions after CONs have been implemented; this would necessitate the re-purposing of some existing personnel, rather than their elimination, as the bill provides no direction as to what these standards should be, and figuring this out, meeting with stakeholders, working with other state agencies, and the required work enforcing it will take substantial time and effort.

Section 20 of Amendment #015533, namely Section 20 provides:

"The agency shall prescribe fees by rule as authorized by this part. The fees shall be in an amount that provides for the cost of administering the implementation and enforcement of this part by the

agency. Fees prescribed by the agency shall be adjusted as necessary to provide that the account is fiscally self-sufficient and that revenues from fees do not exceed necessary and required expenditures."

Would this mean the HSDA will no longer receive any monies from the General Fund? If so, it is probable that the HSDA "account" will be vastly insufficient on 7/1/16 and many points thereafter to enable bills and salaries to be paid.

The only way to make this bill revenue neutral would be an enormous escalation of fees for the remaining 30+ anticipated CON applications to raise approximately $450,000 - $600,000, depending upon whether positions are eliminated (becoming self-sufficient would mean no longer receiving the approximately $150,000 - $200,000 from the General Fund per FY, on top of replacing the revenue foregone by this bill) - an average of $15,000 - $20,000 per application in addition to the current fees. The only way this can occur is via Emergency Rulemaking and anticipated resistance by some regulated entities, and possibly, during legislative oversight.

We sincerely doubt that it is even possible to raise the remaining fees sufficiently to make the HSDA self-sufficient, as CON applications that bring a disproportionate share of revenue to the program/GF are being eliminated by the bill. Application fees are based upon the total project cost, and the most expensive projects are being taken out - ones that bring up to $45,000 per application. Assuming no increase in remaining fees (which will not be the case), we would expect to receive 30-36 applications per FY. Of those 30-35, 18 are currently "minimum fee" applications of $3,000 each. Even with the elimination of several positions on our staff of 9, there's no way that fees can be "adjusted" to raise 1/2 million dollars ($15,000 - $20,000 per application) without a cascading effect of reducing applications even further, with those application fees having to be raised even further. This would result in a death spiral for the certificate of need program.

That is why the assumption that we can simply cut costs and raise fees proportionately for the # of applications lost has no basis in fact, and certainly is not driven by knowledge of our budget.

---

8. *Is funding for this legislation included in the Governor's proposed budget?

Yes **No**

Amount Included if different from estimated cost $_____N/A_____

---

9. Explanation of Abbreviations Used:

---

10. Additional Comments by Preparer:

This bill has a broad caption.

---

11. List Other State Departments/Agencies Fiscally Affected by this Bill or Amendment:

Department of Health

Bureau of TennCare

12. List Bills from Previous Sessions which are Identical/Similar to this Bill or Amendment:

The following bills proposed, to varying degrees, to eliminate CON requirements for certain activities:

2011: HB 525/SB 700

2013: SB 290/HB 854

2015: SB 992/HB 1106

*Commissioner's Signature or Designee:

TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL MEMORANDUM

HB 1730 - SB 1842

April 19, 2016

SUMMARY OF ORIGINAL BILL: Increases, from 30 to 45 days, the time period in which a health care institution is required to notify the Health Services and Developmental Agency (HSDA) prior to any change in ownership.

FISCAL IMPACT OF ORIGINAL BILL:

NOT SIGNIFICANT

SUMMARY OF AMENDMENTS (016256, 016015, 015533): Amendment 015533 deletes all language of the original bill. Exempts certain health care institutions, other than hospitals, from the current requirement to apply and obtain a certificate of need prior to any modification, renovation, or addition to the facility which requires a capital expenditure of $2,000,000 or more. Exempts hospitals from the current requirement to obtain a certificate of need prior to any modification, renovation, or addition which requires a capital expenditure of $5,000,000 or more. Exempts certificate of need requirements for acquisition of major medical equipment, initiation of health care services for extracorporeal lithotripsy, swing beds, discontinuation of any obstetrical or maternity service, establishment of a satellite emergency department facility by a hospital at a location other than the hospital's main campus and magnetic resonance imaging (MRI); provided, a certificate of need is required for the initiation of any health care services for MRI in any county with a population in excess of 250,000 for the purpose of providing MRI services to pediatric patients or for any county with a population of 250,000 or less for all patients, according to the 2010 federal census or any subsequent federal census. Exempts the construction, development, establishment, or modification of birthing centers from requiring a certificate of need. Requires an outpatient diagnostic center, upon obtaining a certificate of need, to become accredited by the American College of Radiology within a time period as defined by the Health Services and Development Agency. Requires a certificate of need prior to increasing the number of MRI machines, except when the purpose is to replace or decommission an existing machine. Creates a new reporting requirement for persons which hold certificates of need for MRI services. Requires a certificate of need prior to the initiation of a health care service for organ transplantation; however, exempts from this requirement any organ transplant program approved by the United Network of Organ Sharing (UNOS) by July 1, 2016, and that has initiated organ transplantation services by January 1, 2017. Authorizes a hospital, rehabilitation facility, or mental health hospital to increase its total number of licensed beds by up to ten percent of its licensed capacity at any one campus over a period of one year without obtaining a certificate of need.

Authorizes any applicant to a certificate of need, whose application has been denied, to request a refund equal to twenty-five percent of the examination fee. Requires the Health Services and Development Agency, in consultation with the Division of Health Planning, the Board for Licensing Health Care Facilities or the Department of Mental Health and Substance Abuse Services, and relevant stakeholders, to develop quality measures applicable to holders of certificates of need. Any certificate holder found in violation of a quality measure will be reported to the Board for Licensing Health Care Facilities or the Department of Mental Health and Substance Abuse Services for appropriate discipline, including a civil penalty of at least $100, but no more than $500 for each instance of violation, and possible revocation of the respective certificate of need.

Requires the Health Services and Development Agency to set fees by rule, in amounts which offset the cost of administering the Agency's duties. Requires a separate account be created within the General Fund which holds collections of civil penalties and fees from, but not limited to, applications of certificates of need, subscriptions, project cost overruns, copying, and contested cases. Establishes that funds remaining in the account at fiscal year-end shall not revert to the General Fund, but remain available for appropriate expenditures.

Amendment 016015 adds new language to the bill as amended by 015533 without making any substantive changes.

Amendment 016256 deletes language in the bill as amended by 015533, thereby maintaining the requirement of a certificate of need prior to the closing of any hospital designated by the Medicare Rural Flexibility Program as a "critical access hospital" or the elimination of any services in such hospital for which a certificate of need is required.

FISCAL IMPACT OF BILL WITH PROPOSED AMENDMENTS:

Increase State Revenue – Exceeds $786,500/HSDA Account

Decrease State Expenditures – Net Impact –$1,138,800/General Fund

Increase State Expenditures - $1,204,300/HSDA Account

Increase Federal Expenditures – Exceeds $86,500

Increase Local Expenditures – Exceeds $1,100*

Other Fiscal Impact – There will be a shift of current fee revenue from the General Fund to the HSDA Account in an amount estimated to be $417,844. The total revenue in the HSDA Account is estimated to be $1,204,300 ($786,456 increased fee revenue + $417,844 current fee revenue) in FY16-17. Fee revenue will be adjusted to an amount sufficient to cover any expenses of the HSDA in future years.

Assumptions for the bill as amended:

- An effective date of July 1, 2016.
- This proposed legislation as amended will result in a decrease in certificate of need (CON) applications filed with the Health Services and Development Agency (HSDA).
- Based on information provided by HSDA, the agency has received between 51 and 67 CON applications annually since 2012. HSDA estimates the reduction of CON applications will result in a net decrease in recurring application fee revenue to the General Fund of approximately $410,000.
- The bill as amended requires the HSDA to charge fees sufficient to remain self-supporting. Currently, the HSDA receives an appropriation for personnel and operating expenses and all revenue collected is deposited into the General Fund. The provisions of the bill will result in the following:
    - A decrease in General Fund expenditures of $1,204,300 based on the Governor's FY16-17 budget document;
    - A shift of General Fund revenue in the amount of $417,844 to the HSDA account based on the average amount of fee revenue deposited over the previous seven fiscal years of $827,844 minus the net decrease of $410,000 in fee revenue proposed by the bill as amended;
    - An increase in revenue to the HSDA account in an amount exceeding $786,456 ($1,204,300 budget amount – $417,844 fee revenue); and
    - An increase in expenditures to the HSDA account estimated to be $1,204,300 based on the current spending authority of the agency (average expenditures have been $1,052,314 over the previous seven fiscal years).
- According to HSDA, a CON application will typically include more than one reason for applying. After a review of applications from 2012 to present, the agency found several that included services to be eliminated by the bill as amended that would have been filed anyway due to the other services included in the application. There are also a few additional CON requirements included in the proposed legislation that offset some of the reduction in workload associated with the reduced number of applications.
- Based on the application filing fees, the CON applications being eliminated account for a disproportionate share of the workload completed by the HSDA. It is assumed that any effect on the Agency's current responsibilities will not significantly affect the overall workload of the HSDA.
- According to a 2016 working paper of George Mason University's Mercatus Center, a decrease in CON requirements will lead to higher utilization of MRI services; however, this increase in utilization varies between hospital and non-hospital settings, where self-referrals are more likely to take place for imaging services. Further, the study could find no support for the hypothesis that the volume of services provided in hospitals is negatively affected by CON policies, but it did find that market entry for nonhospital providers is limited by CON requirements.
- Assuming the provisions of the bill as amended will result in higher utilization of MRI services in non-hospital settings, it is difficult to determine the exact impact that will have on total expenditures to TennCare and the state sponsored health plans.

- While increased utilization will result in increased costs, the study also noted that "hospitals in CON states may attract consumers who would otherwise prefer to travel to a nonhospital provider but who were limited by lower accessibility in CON states."
- If there were a shift from hospital utilization to non-hospital utilization, it is assumed there would be some decrease in expenditures for those claims.
- Also, it is difficult to determine how the prior approval and utilization review policies of both the TennCare and state sponsored health plans will play into the increased utilization for MRI services.
- Due to the number of unknowns and the differences in the plans, it is assumed there will be at least a one percent increase in TennCare costs and at least a two percent increase in costs to the state sponsored health plans.
- The proposed legislation will impact the adult populations living in counties having a population greater than 200,000.
- According to TennCare, there are currently 279 MRI machines in Tennessee.
- According to TennCare, in the five counties with a population greater than 250,000 (Shelby, Davidson, Knox, Rutherford, and Hamilton), there are 150 MRI machines.
- CON requirements will still be applicable in the larger counties for MRI services provided to pediatric patients.
- According to TennCare, approximately 10 of the 150 MRI machines in the five most populous counties are used for pediatrics; therefore, in the five most populous counties there are approximately 140 MRI machines used for adult populations.
- According to TennCare, the average annual expenditures attributed to MRI scans statewide is $26,521,980 based on FY12-13, FY13-14, and FY14-15 expenditures [($27,313,505 + $25,373,185 + 26,879,249) / 3 years].
- An average cost per MRI machine of $95,061 ($26,521,980 / 279 MRI machines).
- A total increase in costs to TennCare of $133,085 (140 machines x $95,061 x 1.0 percent).
- Of the $133,085, $46,602 will be state funds at 35.017 percent and $86,483 will be federal funds at a 64.983 percent match rate.
- According to the Department of Finance and Administration, Division of Benefits Administration, MRI claims for the five counties averaged $1,597,287 over FY12-13, FY13-14, and FY14-15 [($1,755,528 + $1,521,078 + $1,515,255) / 3 years].
- It is estimated that the State Employee, Local Education, and Local Government health plans will incur at least a two percent increase in expenditures across the three plans estimated to be $31,946 ($1,597,287 x 2.0 percent).
- This amount is applied to the three plans as follows:
- State Employee Health Plan is $17,251 ($31,946 x 0.54);
- Local Education Plan is $12,459 ($31,946 x 0.39);
- Local Government Plan is $2,236 ($31,946 x 0.07).
- The state covers 80 percent of the employees' health costs in the State Employee Health Plan resulting in an increase in state expenditures of at least $13,801 ($17,251 x 0.80).
- The state portion of the Local Education Plan is 45 percent for Local Education instructional staff which is approximately 75 percent of LEA employees and 30 percent for support staff which is approximately 25 percent of LEA staff. The increase in state

expenditures is estimated to be at least $5,139 [($12,459 x 0.75 x 0.45) + ($12,459 x 0.25 x 0.30)].

- Each local government that participates in the state sponsored health plan is responsible for paying a percentage of the costs which is determined by the local government. It is assumed that local governments will contribute at least 50 percent of the cost resulting in an increase in local expenditures that will exceed $1,118 ($2,236 x 0.50).
- A net recurring decrease in General Fund state expenditures of $1,138,758 [$1,204,300 - ($46,602 + $13,801 + $5,139)].
- A recurring increase in federal expenditures of $86,483.
- A recurring increase in local expenditures of $1,118.

*Article II, Section 24 of the Tennessee Constitution provides that: *no law of general application shall impose increased expenditure requirements on cities or counties unless the General Assembly shall provide that the state share in the cost.*

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.

Krista M. Lee

Krista M. Lee, Executive Director

/jdb

RULES
OF
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-10
CERTIFICATE OF NEED PROGRAM – SCOPE AND PROCEDURES

TABLE OF CONTENTS

0720—10—.03 STANDARD PROCEDURES FOR CERTIFICATE OF NEED.

(5) Examination Filing Fee.

(a) The amount of the initial fee shall be equal to $3.75 ~~2.25~~ per $1,000 of the estimated capital expenditure involved, but in no case shall this fee be less than $93,000 nor more than $945,000.

(b) Any unpaid balance of litigation costs previously assessed against the applicant or any related entity of the applicant by the Tennessee Health Facilities Commission or the Tennessee Health Services and Development Agency may be offset against any filing fees paid. An application will not be deemed complete until the full filing fee, as well as such off set amounts, are paid in full.

(c) A final fee will be determined upon The Agency's receipt of the final project report. The amount of the final fee shall be the difference between the initial fee and the total fee based on actual final project costs, as such fee is calculated based on $3.75 ~~2.25~~ per $1,000 of project costs, but in no case shall the total fee be less than $93,000 nor more than $945,000.

(6) Distribution of Applications. The Agency will promptly forward a copy of each application deemed complete to the Department of Health, or to the Department of Mental Health and Developmental Disabilities, and in doing so will fix the date on which the review process established by statute and these regulations will commence.

(7) Withdrawal of Applications. An application may be withdrawn at any time by the applicant.

(8) Upon request by interested parties or at the direction of the executive director, the staff of the agency shall conduct a fact-finding public hearing on the application in the area in which the project is to be located. The applicant shall reimburse the Agency for its costs associated with the fact-finding public hearing, including but not limited to costs associated with the hearing location and travel expenses for Agency staff conducting the hearing.

(9) Beginning of the Review Cycle. The review cycle for each application shall begin on the first day of the appropriate month after the application has been deemed complete by the staff of The Agency.

(10) Reviewing Agencies' Actions on Applications.

(a) The Department of Health, or the Department of Mental Health and Developmental Disabilities, shall within seven (7) days from the receipt of a completed application give notice to The Health Services and Development Agency of its receipt in writing. The appropriate reviewing agency shall expeditiously review all applications in a consistent manner and conduct such studies and inquiries thereon as may be determined necessary by the appropriate reviewing agency, by The Health Services and Development Agency's rules, or upon request of The Health Services and Development Agency, to enable it to make a report to The Health Services and Development Agency. Applicants must comply promptly with all reasonable requests made by the appropriate reviewing agency, for additional information for the purpose of this review. Copies of said studies and all correspondence related to the application shall be forwarded to The Health Services and Development Agency by the reviewing agency.

(b) Within sixty (60) days (or thirty (30) days where the application is on the consent calendar), of the date fixed by The Health Services and Development Agency pursuant to Rule 0720—10—.03(4), the reviewing agency shall file its official written report with The Health Services and Development Agency. A copy of this report shall be forwarded by the reviewing agency to the applicant, and to any other person requesting one.

(11~~0~~) Reviewing Agency's Report to The Health Services and Development Agency. The reviewing agency's report shall address at a minimum each of the applicable criteria for certificate of need set forth in the statutes, rules, and the state health plan. The reviewing agency shall clearly set forth any planning methodologies, data bases, and resource materials utilized in making its findings. The reviewing agency may include other information it deems appropriate and informative. The report shall address the following:

(a) The applicant's compliance with the criteria found in Agency Rules 0720-11;

(b) A verification of the methodologies provided by the applicant to meet the criteria specified in (a), as well as identification of any additional methodologies that would further clarify compliance with the criteria;

(c) An assessment of the applicant's compliance with any applicable Guidelines for Growth; and

(d) An analysis of any information received from the TennCare Bureau as to the previous, current and proposed TennCare participation or non-participation of the applicant and any affiliate(s) involved with the project.

(12~~+~~) An applicant may provide written supporting information to its application during the review cycle. Further, the applicant will have the right to respond in writing to the report made by the reviewing agency. The reviewing agency and the Health Services and Development Agency shall receive a copy of the applicant's response to the agency's report not less than ten (10) days prior to the Health Services and Development Agency meeting.

(13~~2~~) Holder of certificate of need. A certificate of need will normally be issued to the person who owns the real property of the institution or facility concerned, provided, however, that a certificate may be issued to:

(a) The lessee or permittee of the property in cases where the property is not specifically designed for the provision of health care services and the lessor is not in the regular business of providing space for health care activities;

(b) The lessee of the property where the terms of the lease convey long-term control of the facility to the lessee;

(c) A management company where the terms of the management agreement convey long-term control of the facility to the management company, and management company also has significant responsibility for implementing and completing the project; or

(d) The person who directly provides equipment or facilities for Health care activities when that person is not the owner of the property or facility.

Authority: *T.C.A. §§ 4—5—202; 68—11—1605; 68—11—1607; 68—11— 1608; 68—11 —1609.*

RULES
OF
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-13
RULES OF PROCEDURE FOR HEARING CONTESTED CASES

TABLE OF CONTENTS

0720—13—.02 CONTESTED CASES BEFORE ADMINISTRATIVE JUDGES SITTING ALONE.

(1) With the exception of declaratory orders referenced below, all petitions for a contested case hearing shall routinely be referred to the Administrative Procedures Division, Department of State for hearing by an Administrative Judge sitting alone on behalf of The Agency. The Agency retains the right, however, to hear any particular contested case on its own behalf.

(2) In all cases, whether heard by an Administrative Judge sitting alone, or by the full Agency, the petitioner and other parties with the exception of The Agency shall bear the cost for all court reporters and transcriptions, and charges billed to the Agency for the Administrative Judge's work/time; in a contested case where the petition is dismissed, whether voluntarily or involuntarily, the petitioning party or parties shall be considered a "losing party" under TCA 68-11-1610.. The original transcript and one copy of the transcript for each member of The Agency shall be provided to The Agency by the other parties, if the case is to be reviewed by the full Agency. ~~Other costs of the proceeding, including the Administrative Judge's costs shall be assessed by The Agency in accordance with T.C.A §§ 68—11—1609 and 68—11—1610.~~

(3) Unless agreed otherwise by the parties, at the beginning of all contested case hearings, Agency counsel shall provide a summary of what the case is about, description of the project, and introduce into evidence the application, the reviewing agency's report and the staff Summary, and the minutes of The Agency reflecting the action that was taken before The Agency. In no event shall this provision mean that The Agency is a neutral party in contested cases, or that its counsel represents the interests of any party other than The Agency.

(4) In all cases, whether heard by an Administrative Judge sitting alone, or by the full Agency, the party petitioning for such hearing shall present its case first, unless the parties agree otherwise.

Authority: *T.C.A §§ 4—5—202; 4—5—223; 4—5—310; 4—5—314; 68—11—1605; 68—11—1609; 68—11—1610.*